



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ELITE HEALTHCARE NORTH DALLAS
PO BOX 1210
FRISCO TX 75034

Respondent Name

PLANO INDEPENDENT SCHOOL DISTRICT

Carrier's Austin Representative

Box Number 19

MFDR Tracking Number

M4-13-3156-01

MFDR Date Received

JULY 29, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please note this patient had PREAUTHORIZATION, and per RULE 134.600, these need paid. You have paid some in full and not others which doesn't make sense. The 'timed exercises' are on all of the documentation which is attached. The compensable injury is the left shoulder, so this is the area that the physical therapy was done."

Amount in Dispute: \$1,350.64

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please see attached summary of position regarding the DOS in dispute."

Response Submitted by: Flahive, Ogden & Latson, PO Drawer 201329, Austin, TX 78720

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 9, 2010 through May 25, 2010	Office Visits and Physical Therapy	\$1,350.64	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

- 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 150 – Payer deems the information submitted does not support this level of service.
 - 16 – Claim/service lacks information which is needed for adjudication.
 - W1 – Workers Compensation State Fee Schedule adjustment.
 - 197 – Precertification/authorization/notification absent.
 - 50 – These are non-covered services because this is not deemed a medical necessity by the payer.

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issue

1. Did the requestor waive the right to medical fee dispute resolution?

Findings

28 Texas Administrative Code §133.307(c)(1) states: "Timeliness. A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. (A) A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The dates of the service in dispute are February 9, 2010 through May 25, 2010. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on July 29, 2013. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307, subparagraph (B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

The Division finds that the requestor has waived the right to medical fee dispute resolution for the services in dispute. For that reason, the merits of the issues raised by both parties to this dispute have not been addressed.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____	_____	October 24, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.